STATE OF ARIZONA ACTIVE EMPLOYEE ENROLLMENT/CHANGE 2004-2005

☐ NEW EMPLOYEE ☐ QUALIFIED LIFE EVENT ☐ ADDRESS CHANGE ☐ TERMINATION

AGENCY CODE	AGENCY	DATE AGENCY RECEIVED	EFFECTIVE DATE

DO NOT WRITE ABOVE THIS LINE - FOR AGENCY USE ONLY

A. EMPLOYEE IDENTIFICATION

LAST NAME, FIRST NAME, M.I.	Employee ID Number or SSN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	DATE OF EMPLOYMENT
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
SPOUSE'S LAST NAME, FIRST NAME	SPOUSE'S EMPLOYER	EMPLOYEE CURRENT SALARY	

B. MEDICAL PLAN (Monthly Costs Listed)

☐ I DECLINE MEDICAL COVERAGE

	SINGLE	FAMILY
CENTRAL REGION: MARICOPA, GILA, & PINAL COUNTIES		
RAN+AMN (HMA) EPO	☐ $25.00	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	☐ $25.00	☐ $125.00
United Healthcare (UHC) EPO	☐ $35.00	☐ $135.00
Arizona Foundation (AZF) PPO	☐ $140.00	☐ $390.00
United Healthcare (UHC) PPO	☐ $150.00	☐ $400.00
SOUTHERN REGION: PIMA AND SANTA CRUZ COUNTIES		
RAN+AMN (HMA) EPO	☐ $25.00	☐ $125.00
Schaller Anderson Healthcare (SA) EPO	☐ $25.00	☐ $125.00
United Healthcare (UHC) EPO	☐ $35.00	☐ $135.00
Arizona Foundation (AZF) PPO	☐ $140.00	☐ $390.00
United Healthcare (UHC) PPO	☐ $150.00	☐ $400.00
NORTH REGION: YAVAPAI, COCONINO, NAVAJO, AND APACHE COUNTIES		
RAN+AMN (HMA) EPO	☐ $25.00	☐ $125.00
Arizona Foundation (AZF) PPO	☐ $140.00	☐ $390.00
SOUTHEASTERN REGION: GRAHAM, GREENLEE, AND COCHISE COUNTIES		
RAN/AMN (HMA) EPO	☐ $25.00	☐ $125.00
Arizona Foundation (AZF) PPO	☐ $140.00	☐ $390.00
WESTERN REGION: MOHAVE, LA PAZ, AND YUMA COUNTIES		
RAN+AMN (HMA) EPO	☐ $25.00	☐ $125.00
Arizona Foundation (AZF) PPO	☐ $140.00	☐ $390.00
Out Of State		
Beech Street PPO	☐ $25.00	☐ $125.00

STATE OF ARIZONA ACTIVE EMPLOYEE ENROLLMENT/CHANGE 2004-2005 CONTINUED

C. DENTAL PLAN (Monthly Costs Listed)	SINGLE COVERAGE	FAMILY COVERAGE
☐ **I DECLINE DENTAL COVERAGE**		
DELTA DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	☐ $12.10	☐ $45.90
METLIFE DENTAL INDEMNITY/PPO IN ARIZONA AND OUT-OF-STATE	☐ $12.10	☐ $42.46
EMPLOYERS DENTAL SERVICES (EDS) PRE-PAID IN-STATE ONLY	☐ $3.54	☐ $16.72
FORTIS BENEFITS PRE-PAID IN-STATE ONLY	☐ $4.68	☐ $18.02

D. VISION PLAN (Monthly Cost Listed)

☐ **I DECLINE VISION COVERAGE** ☐ AVESIS SINGLE COVERAGE $6.34 ☐ AVESIS FAMILY COVERAGE $17.18

E. DEPENDENTS - List all eligible dependents to be enrolled in medical, dental, and/or vision plans

LAST NAME, FIRST NAME, M.I. (LIST LAST NAME IF IT IS DIFFERENT FROM EMPLOYEE MEMBER). USE AN ADDITIONAL FORM FOR MORE THAN 6 DEPENDENTS	DATE OF BIRTH (MM/DD/YY) **REQUIRED**	MEDICARE	RELATIONSHIP CODE	MALE OR FEMALE	FULL TIME STUDENT Y or N	DISABLED Y or N	PCP/ DENTIST I.D. NUMBER	ADD OR DELETE A OR D
Employee		**A=Medicare A B=Medicare B C=Medicare A & B D=Medicare unknown E=No Medicare**	**S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild**					
Spouse		☐ A ☐ B ☐ C ☐ D ☐ E	☐ S	☐M ☐F				
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F				
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F				
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F				
		☐ A ☐ B ☐ C ☐ D ☐ E	☐ C ☐ G ☐ P ☐ T	☐M ☐F				

F. STANDARD SHORT-TERM DISABILITY

☐ **I DECLINE STANDARD SHORT-TERM DISABILITY** ☐ **I ELECT STANDARD SHORT-TERM DISABILITY**

G. STANDARD SUPPLEMENTAL LIFE INSURANCE AND DEPENDENT LIFE INSURANCE

Employee coverage maximum $300,000 in multiples of $5,000 not to exceed 3 times annual salary. Increases may not exceed $20,000 per plan year.

☐ **I DECLINE SUPPLEMENTAL LIFE INSURANCE**

☐ Total amount of employee coverage $_____

☐ Non-Smoker (I have not smoked in 6 months, additional $1,000 benefit if Supplemental Life Insurance is elected).

Dependent Life Insurance

☐ **I DECLINE DEPENDENT LIFE INSURANCE**

☐ $2,000 $0.94/MONTH ☐ $4,000 $1.88/MONTH

☐ $6,000 $2.82/MONTH ☐ $12,000 $5.64/MONTH

☐ $15,000 $7.06/MONTH

H. PRIMARY BENEFICIARY (List additional or Trust information on a separate form which you may obtain from your benefit liaison)

Beneficiary Last Name, First Name Social Security Number (optional)	Date of Birth
Beneficiary Street, City, State, Zip Code	Phone No. ( )

I. EMPLOYEE AUTHORIZATION AND SIGNATURE

I hereby certify that under penalty of perjury that the information I have provided in this application for employee benefits, including address and spouse/dependent information is correct and true. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law. In additon, I have read and understand the declarations on the reverse side of the form.

SIGNATURE:_____ DATE:_____

Return form to: ADOA Benefits Office, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007 **Revised 7/29/04**